FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021550

Facility Name: BOURBONNAIS TERRACE

Address: 133 MOHAWK DR. (Number) BOURBONNAIS (City) 60914 (Zip Code)

County: KANKAKEE

Telephone Number: (847) 937-4790 Fax # (847) 937-9321

IDPA ID Number: 36-2821184

Date of Initial License for Current Owners: 01/01/78

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	64,947	1,183		66,130	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,947	1,183		66,130	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.97%

D. How many bed-hold days during this year were paid by Public Aid?
3,819 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	273,182	18,386	9,495	301,063		301,063	0	301,063			1
2	Food Purchase		230,900		230,900		230,900	(1,380)	229,520			2
3	Housekeeping	199,031	15,827	0	214,858		214,858	0	214,858			3
4	Laundry	101,739	14,015	1,373	117,127		117,127	0	117,127			4
5	Heat and Other Utilities			133,220	133,220		133,220	508	133,728			5
6	Maintenance	56,707	17,415	25,589	99,711		99,711	6,372	106,083			6
7	Other (specify):*			11,849	11,849		11,849	141	11,990			7
8	**TOTAL General Services**	630,659	296,543	181,526	1,108,728	0	1,108,728	5,641	1,114,369			8
	B. Health Care and Programs											
9	Medical Director	0		6,500	6,500		6,500	0	6,500			9
10	Nursing and Medical Records	1,595,247	32,340	19,613	1,647,200		1,647,200	0	1,647,200			10
10a	Therapy	134,566		7,199	141,765		141,765	0	141,765			10a
11	Activities	92,437	2,717	2,441	97,595		97,595	0	97,595			11
12	Social Services	130,731		2,255	132,986		132,986	0	132,986			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,952,981	35,057	38,008	2,026,046	0	2,026,046	0	2,026,046			16
	C. General Administration											
17	Administrative	67,207		565,500	632,707		632,707	(524,656)	108,051			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			52,332	52,332		52,332	12,243	64,575			19
20	Dues, Fees, Subscriptions & Promotions			13,936	13,936		13,936	(3,688)	10,248			20
21	Clerical & General Office Expenses	134,254	15,838	155,613	305,705		305,705	(83,033)	222,672			21
22	Employee Benefits & Payroll Taxes			431,782	431,782		431,782	(560)	431,222			22
23	Inservice Training & Education			2,964	2,964		2,964	118	3,082			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			8,659	8,659		8,659	823	9,482			25
26	Insurance-Prop.Liab.Malpractice			104,724	104,724		104,724	4,255	108,979			26
27	Other (specify):*			0	0		0	11,376	11,376			27
28	**TOTAL General Administration**	201,461	15,838	1,335,510	1,552,809	0	1,552,809	(583,122)	969,687			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,785,101	347,438	1,555,044	4,687,583	0	4,687,583	(577,481)	4,110,102			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BOURBONNAIS TERRACE #0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,318	54,318		54,318	8,729	63,047			30
31	Amortization of Pre-Op. & Org.			56,571	56,571		56,571	0	56,571			31
32	Interest			277,329	277,329		277,329	2,390	279,719			32
33	Real Estate Taxes			69,075	69,075		69,075	1,150	70,225			33
34	Rent-Facility & Grounds			14,781	14,781		14,781	0	14,781			34
35	Rent-Equipment & Vehicles			24,712	24,712		24,712	5,259	29,971			35
36	Other (specify):*				0		0	(14,781)	(14,781)			36
37	**TOTAL Ownership**			496,786	496,786	0	496,786	2,747	499,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			107,858	107,858		107,858	0	107,858			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	107,858	107,858	0	107,858	0	107,858			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,785,101	347,438	2,159,688	5,292,227	0	5,292,227	(574,734)	4,717,493			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,593	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,380)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		21		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(3,376)	20		20
21	Owner or Key-Man Insurance	(560)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(280)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(961)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(695)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (659)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(574,075)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (574,075)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (574,734)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BOURBONNAIS TERRACE

ID# 0021550

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2255	6	1
2	STAFF DEVELOPMENT	(2,950)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(695)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BOURBONNAIS TERRACE **#** 0021550 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,380)	0	0	0	0	0	0	0	0	0	0	(1,380)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	508	0	0	0	0	0	0	0	508	5
6	Maintenance	2,255	0	2,697	1,420	0	0	0	0	0	0	0	6,372	6
7	Other (specify):*	0	0	141	0	0	0	0	0	0	0	0	141	7
8	**TOTAL General Services**	875	0	2,838	1,928	0	0	0	0	0	0	0	5,641	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(524,656)	0	0	0	0	0	0	0	0	0	(524,656)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	585	11,538	120	0	0	0	0	0	0	0	12,243	19
20	Fees, Subscriptions & Promotions	(4,617)	0	929	0	0	0	0	0	0	0	0	(3,688)	20
21	Clerical & General Office Expenses	(2,950)	9,053	(89,642)	506	0	0	0	0	0	0	0	(83,033)	21
22	Employee Benefits & Payroll Taxes	(560)	0	0	0	0	0	0	0	0	0	0	(560)	22
23	Inservice Training & Education	0	0	118	0	0	0	0	0	0	0	0	118	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	618	205	0	0	0	0	0	0	0	0	823	25
26	Insurance-Prop.Liab.Malpractice	0	1,058	3,066	131	0	0	0	0	0	0	0	4,255	26
27	Other (specify):*	0	3,797	7,579	0	0	0	0	0	0	0	0	11,376	27
28	**TOTAL General Administration**	(8,127)	(509,545)	(66,207)	757	0	0	0	0	0	0	0	(583,122)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,252)	(509,545)	(63,369)	2,685	0	0	0	0	0	0	0	(577,481)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	6,593	406	519	1,211	0	0	0	0	0	0	0	8,729	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	567	1,823	0	0	0	0	0	0	0	2,390	32
33	Real Estate Taxes	0	0	0	1,150	0	0	0	0	0	0	0	1,150	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,777	3,482	0	0	0	0	0	0	0	0	5,259	35
36	Other (specify):*	0	0	0	(14,781)	0	0	0	0	0	0	0	(14,781)	36
37	**TOTAL Ownership**	6,593	2,183	4,568	(10,597)	0	0	0	0	0	0	0	2,747	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(659)	(507,362)	(58,801)	(7,912)	0	0	0	0	0	0	0	(574,734)	45

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENERPRISES	LINCOLNWOOD	MGMT CONSULT/
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 544,500	EMI ENTERPRISES, INC		$	$ (544,500)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				19,844	19,844	4
5	V	19	ACCOUNTING FEES				585	585	5
6	V	21	OFFICE EXPENSE				9,053	9,053	6
7	V	25	TRANSPORTATION				618	618	7
8	V	26	INSURANCE				1,058	1,058	8
9	V	27	EMPLOYEE BENEFITS				3,797	3,797	9
10	V	30	DEPRECIATION				406	406	10
11	V	35	AUTO LEASE				1,777	1,777	11
12	V								12
13	V								13
14	Total			$ 544,500			$ 37,138	$ * (507,362)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 134,748	EKS MANAGEMENT, INC.		$	$ (134,748)	15
16	V								16
17	V								17
18	V	6	PAINTING SALARIES				2,697	2,697	18
19	V	7	SCAVENGER				141	141	19
20	V	19	PROFESSIONAL FEES				11,538	11,538	20
21	V	20	WANT ADS				929	929	21
22	V	21	OFFICE EXPENSE				45,106	45,106	22
23	V	23	SEMINARS				118	118	23
24	V	25	TRANSPORTATION				205	205	24
25	V	26	INSURANCE				3,066	3,066	25
26	V	27	EMPLOYEE BENEFITS				7,579	7,579	26
27	V	30	DEPRECIATION				519	519	27
28	V	32	INTEREST - INSUR. FIN				567	567	28
29	V	35	EQUIPMENT RENT				3,482	3,482	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 134,748			$ 75,947	$ * (58,801)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 14,781	IME REALTY CORP.		$	$ (14,781)	15
16	V								16
17	V								17
18	V	5	UTILITIES				508	508	18
19	V	6	REPAIRS & MAINTENANCE				1,420	1,420	19
20	V	19	PROFESSIONAL FEES				120	120	20
21	V	21	OFFICE EXPENSE				506	506	21
22	V	26	INSURANCE				131	131	22
23	V	30	DEPRECIATION				1,211	1,211	23
24	V	32	INTEREST				1,823	1,823	24
25	V	33	RE TAX				1,150	1,150	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,781			$ 6,869	$ * (7,912)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BERNARD COHEN	GENERAL PARTNE	ADMINISTRATION		SEE ATTACHED SCHEDULE			MGMT FEE	$ 21,000	17-3	1
2	MORRIS ESFORMES	GENERAL PARTNE	ADMINISTRATION					SALARY	19,844	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 40,844		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	616,513	11	$ 185,000	$ 185,000	66,130	$ 19,844	1
2	19	ACCOUNTING FEES	PATIENT DAYS	616,513	11	5,451		66,130	585	2
3	21	OFFICE EXPENSE	PATIENT DAYS	616,513	11	84,399	60,672	66,130	9,053	3
4	25	TRANSPORTATION	PATIENT DAYS	616,513	11	5,763		66,130	618	4
5	26	INSURANCE	PATIENT DAYS	616,513	11	9,863		66,130	1,058	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	35,399		66,130	3,797	6
7	30	DEPRECIATION	PATIENT DAYS	616,513	11	3,788		66,130	406	7
8	35	AUTO LEASE	PATIENT DAYS	616,513	11	16,569		66,130	1,777	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 346,232	$ 245,672		$ 37,138	25

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MGMT,
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING / DECORATING	PATIENT DAYS	616,513	11	$ 25,141	$	66,130	$ 2,697	1
2	7	SCAVENGER	PATIENT DAYS	616,513	11	1,310		66,160	141	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	616,513	11	107,563	91,129	66,130	11,538	3
4	20	WANT ADS	PATIENT DAYS	616,513	11	8,660		66,130	929	4
5	21	OFFICE EXPENSE	PATIENT DAYS	616,513	11	420,511		66,130	45,106	5
6	23	SEMINARS	PATIENT DAYS	616,513	11	1,100		66,130	118	6
7	25	TRANSPORTATION	PATIENT DAYS	616,513	11	1,912		66,130	205	7
8	26	INSURANCE	PATIENT DAYS	616,513	11	28,579		66,130	3,066	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	70,657		66,130	7,579	9
10	30	DEPRECIATION	PATIENT DAYS	616,513	11	4,837		66,130	519	10
11	32	INTEREST - INSURANCE FIN	PATIENT DAYS	616,513	11	5,286		66,130	567	11
12	35	EQUIPMENT RENT	PATIENT DAYS	616,513	11	32,463		66,130	3,482	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 708,019	$ 91,129		$ 75,947	25

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	203,249	11	$ 6,990	$	14,781	$ 508	1
2	6	REPAIRS & MAINTENANCE	INCOME	203,249	11	19,525		14,781	1,420	2
3	19	PROFESSIONAL FEES	INCOME	203,249	11	1,650		14,781	120	3
4	21	OFFICE EXPENSE	INCOME	203,249	11	6,958		14,781	506	4
5	26	INSURANCE	INCOME	203,249	11	1,798		14,781	131	5
6	30	DEPRECIATION	INCOME	203,249	11	16,647		14,781	1,211	6
7	32	INTEREST	INCOME	203,249	11	25,074		14,781	1,823	7
8	33	RE TAX	INCOME	203,249	11	15,815		14,781	1,150	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 94,457	$		$ 6,869	25

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LASALLE NATIONAL BANK		X	MORTGAGE	VARIES	08/01/95	$ 4,910,000	$ 3,989,958	07/13/15	prime +	$ 227,232	1
2	LASALLE NATIONAL BANK		x	MORTGAGE	$27,208.30	11/01/01	4,004,402	3,989,958	10/31/26		39,973	2
3												3
4												4
5												5
	Working Capital											
6	LASALLE NATIONAL BANK		X	LINE OF CREDIT	INTEREST	REVOLV	220,000	56,000	PRIME+	prime +	7,597	6
7			X	INSURANCE FINANCING							2,527	7
8	RELATED PARTY										2,390	8
9	TOTAL Facility Related				$27,208.30		$ 9,134,402	$ 8,035,916			$ 279,719	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 9,134,402	$ 8,035,916			$ 279,719	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	68,891	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	68,983	2
3. Under or (over) accrual (line 2 minus line 1).	$	92	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	69,290	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	(307)	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	69,075	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	56,626	8
	1997	60,461	9
	1998	61,858	10
	1999	60,602	11
	2000	68,983	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BOURBONNAIS TERRACE COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0021550

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-09-17-300-013	NURSING HOME	$ 614.52	$ 614.52
2.	17-09-17-300-020	NURSING HOME	$ 68,368.28	$ 68,368.25
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 68,982.80	$ 68,982.77

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,232 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	165,000		$ 184,000	1
2				3,600	2
3	TOTALS	165,000		$ 187,600	3

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	197		1975	1974	$ 1,838,000	$	25	$	$	$ 1,838,000	4
5											5
6	RELATED					993		993			6
7	PARTY										7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1981	54,211		10			54,211	9
10	LEASEHOLD IMPROVEMENT			1982	17,608		10			17,608	10
11	ROOFING			1983	1,875		15			1,875	11
12	ROOFING			1984	6,215	249	18	249		5,509	12
13	IMPROVEMENTS			1987	21,900	695	31.5	695		10,425	13
14	STONE DRIVE			1990	7,800	248	31.5	248		2,821	14
15	IMPROVEMENTS			1991	26,075	828	31.5	828		8,452	15
16	IMPROVEMENTS			1992	38,485	1,222	31.5	1,222		11,609	16
17	ROOFING			1993	21,500	551	39	551		6,018	17
18	GUTTERS			1994	7,248	186	39	186		1,418	18
19	CONCRETE			1994	7,967	204	39	204		1,505	19
20	FLOOR			1995	766	20	39	20		139	20
21	TILE			1995	1,580	40	39	40		280	21
22	FLOOR			1995	934	24	39	24		165	22
23	CONCRETE			1995	2,500	64	39	64		392	23
24	TILES			1996	5,820	149	39	149		838	24
25	SEWERS			1996	10,000	256	39	256		1,419	25
26	TILES			1996	16,056	412	39	412		2,283	26
27	ROOF			1996	21,650	555	39	555		3,030	27
28	CONCRETE			1996	7,949	204	39	204		1,097	28
29	SCREENS			1996	1,424	37	39	37		196	29
30	DISPOSER BASE UNIT			1996	732	19	39	19		96	30
31	FLOORING IMPROVEMENTS			1997	16,979	435	39	435		1,976	31
32	WINDOWS			1998	1,680	43	39	43		172	32
33	INSTALL NEW SIGN			1998	2,643	68	39	68		207	33
34	NURSES STATION			1999	3,520	90	39	90		252	34
35	KITCHEN A/C UNIT			1999	6,696	172	39	172		423	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FURNISHINGS - CARPET/WALLPAPER	1999	$ 16,384	$ 4,012	7	$ 4,012	$	$ 10,365	37
38	FENCE	2000	2,800	187	15	187		335	38
39	DUCT WORK	2000	14,000	509	27.5	509		573	39
40	IN WALLS HEATERS	2000	12,407	451	27.5	451		883	40
41	IN WALLS HEATERS	2000	4,378	16	27.5	16		49	41
42	FURNISHINGS	2000	23,248	3,321	7	3,321		6,643	42
43	DOORS	2000	881	32	27.5	32		63	43
44	IMPROVEMENT - BATHROOM	2001	2,782	55	27.5	55		55	44
45	IMPROVEMENT - HVAC UNITS	2001	15,737	310	27.5	310		310	45
46	IMPROVEMENT - BUILT IN CLOSETS	2001	60,000	1,182	27.5	1,182		1,182	46
47	IMPROVEMENT - WINDOWS	2001	2,995	109	27.5	109		109	47
48	FURNISHINGS - TILE FLOOR	2001	5,208	1,042	5	1,042		521	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,310,633	$ 18,990		$ 18,990	$ 0	$ 1,993,504	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 379,383	$ 29,424	$ 39,466	$ 10,042	7-10 YR	$ 239,075	71
72	Current Year Purchases	34,481	6,897	3,448	(3,449)	5-10 YR	3,448	72
73	Fully Depreciated Assets	284,810			0		284,810	73
74	RELATED PARTY		1,143	1,143	0			74
75	TOTALS	$ 698,674	$ 37,464	$ 44,057	$ 6,593		$ 527,333	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,196,907	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 56,454	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 63,047	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,593	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,520,837	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				14,781			4
5								5
6								6
7	TOTAL				$ 14,781 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 21,307 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT, NURS, ACTIV	1999 FORD E-350	$ 550.99	$ 3,405	17
18					18
19					19
20					20
21	TOTAL		$ 550.99	$ 3,405	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 180,833	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,099,428		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	155,824		7
8	Accounts Receivable (owners or related parties)	1,994,562		8
9	Other(specify): Employee loans, adv wages	13,500		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,444,147	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	187,600		13
14	Buildings, at Historical Cost	1,838,000		14
15	Leasehold Improvements, at Historical Cost	472,633		15
16	Equipment, at Historical Cost	698,674		16
17	Accumulated Depreciation (book methods)	(2,619,754)		17
18	Deferred Charges	35,369		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): AMORT OF DEF LOAN COST	(699)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 611,823	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,055,970	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 459,918	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	56,000		29
30	Accrued Salaries Payable	83,629		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,912		31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,290		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	62,907		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 766,656	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,989,958		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,989,958	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,756,614	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (700,644)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,055,970	$ 0	48

***(See instructions.)**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (814,843)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (814,843)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	660,081	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) WITHDRAWALS	(545,882)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 114,199	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (700,644)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,822,071	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,822,071	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	130,237	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 130,237	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,952,308	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,108,728	31
32	Health Care	2,026,046	32
33	General Administration	1,552,809	33
	B. Capital Expense		
34	Ownership	496,786	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	107,858	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,292,227	40
41	**Income before Income Taxes (line 30 minus line 40)****	660,081	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 660,081	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,752	1,991	$ 49,096	$ 24.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,507	8,451	150,934	17.86	3
4	Licensed Practical Nurses	22,557	25,345	412,621	16.28	4
5	Nurse Aides & Orderlies	74,687	83,918	961,701	11.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,418	12,671	134,566	10.62	8
9	Activity Director					9
10	Activity Assistants	8,610	9,461	92,437	9.77	10
11	Social Service Workers	12,063	12,309	130,731	10.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,587	26,394	273,182	10.35	15
16	Dishwashers					16
17	Maintenance Workers	3,498	3,533	56,707	16.05	17
18	Housekeepers	19,314	23,554	199,031	8.45	18
19	Laundry	7,505	8,528	101,739	11.93	19
20	Administrator	6,706	7,211	67,207	9.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,078	14,791	134,254	9.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	2,080	2,240	20,895	9.33	33
34	TOTAL (lines 1 - 33)	211,362	240,397	$ 2,785,101 *	$ 11.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,495	1-3	35
36	Medical Director	O	6,500	9-3	36
37	Medical Records Consultant	N	2,573	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	L	7,760	10-3	39
40	Physical Therapy Consultant	Y	3,004	10a-3	40
41	Occupational Therapy Consultant		4,195	10a-3	41
42	Respiratory Therapy Consultant	F	0	10a-3	42
43	Speech Therapy Consultant	E	0	10a-3	43
44	Activity Consultant	E	2,441	11-3	44
45	Social Service Consultant	S	2,255	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 38,223		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 1,055		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 1,055		53

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEBRA WOOD	ADMIN	0	$ 67,207
		0	0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,207

B. Administrative - Other

Description	Amount
EMI ENTERPRISE - MANAGEMENT FEE	$ 544,500
BERNARD COHEN - MANAGEMENT FEE	21,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 565,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LAWRENCE SCHWARTZ	LEGAL	$ 18,000
MCBRIDE, BAKER & COLE	LEGAL	1,583
LINCOLNWOOD FUNDING	REMARKETING FEE	5,005
ALPHA DATA	DATA PROCESSING	4,379
MAXXSOURCE	DATA PROCESSING	1,375
MIDAMERICA	DATA PROCESSING	1,320
NURSING CARE SYSTEMS	DATA PROCESSING	8,061
SOURCE TECH	DATA PROCESSING	273
KRUPNICK, BOKOR	ACCOUNTING	11,100
PERSONNEL PLANNERS	UC CONSULTANT	1,236
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 52,332

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,694
Unemployment Compensation Insurance	13,998
FICA Taxes	213,061
Employee Health Insurance	116,456
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	13
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	560
INSURANCE - EXECUTIVE LIFE VI 21	(560)
TOTAL (agree to Schedule V, line 22, col.8)	$ 431,222

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,682
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,241
RELATED PARTY	929
CONTRIBUTIONS	3,376
DUES & SUBSCRIPTIONS	5,207
LICENSES & PERMITS	430
CONTRIBUTIONS	(3,376)
Less: Public Relations Expense	(0)
Non-allowable advertising	(280)
Yellow page advertising	(961)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,248

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1997	$ 6,090	3	$ 2,030	$ 2,030	$ 1,015	$	$	$	$	$	$
2	PAINT/DECORATING	1998	2,585	3	431	862	862	430					
3	PAINT/DECORATING	1999	2,551	3		425	850	850	426				
4	PAINT/DECORATING	2000	2,926	3			488	975	975	488			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 14,152		$ 2,461	$ 3,317	$ 3,215	$ 2,255	$ 1,401	$ 488	$	$	$

Facility Name & ID Number BOURBONNAIS TERRACE **#** 0021550 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE - $ 5,207**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **107,858**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BOURBONNAIS TERRACE **#0021550** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,495	
	REPAIRS & MAINTENANCE		0	
			0	9,495
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,373	
			0	1,373
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		20,774	
	ELECTRICITY		62,554	
	WATER		43,366	
	CABLE TV - LOBBY		6,526	
			0	133,220
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,249	
	PAINTING & DECORATING		1,458	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,262	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,112	
	FIRE SERVICE		1,508	
			0	
			0	
			0	25,589
7	**OTHER**			
	SCAVENGER		11,393	
	SECURITY SERVICE		456	11,849
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,500	6,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	1,055	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,573	
	PHARMACY CONSULTANT	XVIII B 39-2	7,760	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	5,200	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		3,025	
				19,613
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,004	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	4,195	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	7,199
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,441	
			0	2,441
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,255	
			0	2,255
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BOURBONNAIS TERRACE **#0021550** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	565,500	565,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,409	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	36,923	
			0	52,332
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	280	
	EMPLOYEE WANT ADS	XIX F	3,682	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	5,207	
	LICENSES & PERMITS	XIX F	430	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	961	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,876	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	13,936
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		3,044	
	EQUIPMENT REPAIR & MAINTENANCE		714	
	OUTSIDE CLERICAL SERVICES		134,748	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		14,157	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		2,950	155,613

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	213,061	
	UNEMPLOYMENT COMPENSATION	XIX D	13,998	
	WORKERS COMPENSATION INSURANC	XIX D	87,694	
	HOSPITALIZATION INSURANCE	XIX D	116,456	
	EMPLOYEE BENEFITS - OTHER	XIX D	13	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	560	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	431,782
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,964	2,964
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,659	8,659
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		104,724	104,724
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,555,044

BOURBONNAIS TERRACE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	230,900	PATIENT MEALS	198390
LESS SALES TAX	1,370	ADD EMPLOYEE MEALS	0
NET FOOD	229530	TOTAL MEALS/YEAR	198390
TOTAL PATIENT CENSUS	66,130	NET FOOD	229530
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	198390
TOTAL PATIENT MEALS	198390	COST PER MEAL	1.16
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		